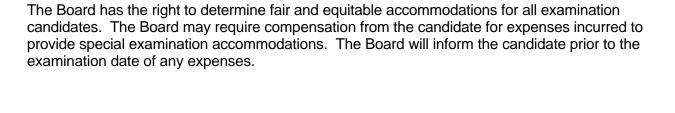
SD Board of Counselor Examiners

DOCUMENTATION OF DISABILITY AND RELATED NEEDS National Counselor Examination or National Clinical Mental Health Counseling Examination

If you are requesting special accommodations due to a disability, please complete and submit this form by the deadline indicated. The information requested below and any documentation regarding your disability and your need for accommodation(s) in testing will be considered strictly confidential.

Name:	Social Security:
Address:	SD Zip
Phone:	Fax:
I have the following disability:	
I need the following accommodation(s):	
Signature:	Date:
Verifica	ation by Third Party
If you have a disability that requires special accommodation(s) in testing, please have this section completed by the appropriate professional (learning specialist, doctor, psychologist, psychiatrist, etc.) to CERTIFY that your disabling condition requires the requested test accommodation(s).	
I have known	since
This individual has the following disability:	
Diagnosed by me with the following tests or studies on this date:	
I recommend the following accommodation(s) be provided for this individual:	
My Name:	Phone:
Professional Title:	
Address:	ST Zip
Certified by:	Date:

DISCLAIMER



The Examination Candidate must return the completed original form no less than 30 days prior to the examination date in order to be eligible.

South Dakota Board of Counselor Examiners 1116 S. Minnesota Avenue PO Box 1822 Sioux Falls, SD 57101-1822 605 / 331-2927